WELCOME TO OUR OFFICE

Please PRINT the following information which is important for our records and your health. *All information is strictly confidential.*

Patient's Full Name _____ Birth Date _____ Age _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Male ☐ Female ☐

Home Address _____ City _____ State _____ Zip _____

Business Address _____ City _____ State _____ Zip _____

Employed By _____ Occupation _____

Telephone: Residence _____ Business _____ Ext. _____ Cell _____

E-mail _____ Prefer contact by: E-mail ☐ Phone ☐ Mail ☐

Spouse or Guardian's Full Name _____ Occupation _____

Employed by _____ Telephone _____

Referred By _____ Former Dentist _____ Date Last Seen _____

Dental Insurance Company _____ Patient's Social Security Number _____

Who Will Pay This Account? _____ Address _____ Telephone _____

Guarantor's Social Security Number _____ Drivers License # _____

Physician _____ Date of Last Physical _____

MEDICAL HISTORY

1. Reason for visit _____
2. Are you having pain or discomfort at this time? ..... YES ☐ NO ☐
3. Do you feel very nervous about having dental treatment? ..... YES ☐ NO ☐
4. Have you ever had a bad experience in a dental office? ..... YES ☐ NO ☐
5. Have you ever been a patient in the hospital during the last two years? ..... YES ☐ NO ☐
6. Have you been under the care of a medical doctor during the last two years? ..... YES ☐ NO ☐
7. Have you taken any medicine or drugs during the past two years? Please list ..... YES ☐ NO ☐
8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? Please list ..... YES ☐ NO ☐
9. Have you ever had excessive bleeding requiring special treatment? ..... YES ☐ NO ☐
10. Circle any of the following which you have had or have at present:

Heart Failure	Anemia	Thyroid Disease	Yellow Jaundice
Heart Disease or Attack	Stroke	X-Ray or Cobalt Treatment	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Drug Addiction
High Blood Pressure	Ulcers	Arthritis	Hemophilia
Heart Murmur	Emphysema	Rheumatism	Venereal Disease (Syphilis, Gonorrhea)
Rheumatic Fever	Cough	Cortisone Medicine	Cold Sores
Congenital Heart Lesions	Tuberculosis (TB)	Glaucoma	Genital Herpes
Scarlet Fever	Asthma	Pain in Jaw or Joints	Epilepsy or Seizures
Artificial Heart Valve	Hay Fever	HIV / AIDS	Fainting or Dizzy Spells
Heart Pacemaker	Sinus Trouble	Hepatitis A (infectious)	Nervousness
Heart Surgery	Allergies or Hives	Hepatitis B, C (serum)	Psychiatric Treatment
Artificial Joint	Diabetes	Liver Disease	Sickle Cell Disease
			Bruise Easily

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES ☐ NO ☐
12. Do your ankles swell during the day? ..... YES ☐ NO ☐
13. Do you ever wake up from sleep short of breath? ..... YES ☐ NO ☐
14. Are you on a special diet? ..... YES ☐ NO ☐
15. Has your medical doctor ever said you have a cancer or tumor? ..... YES ☐ NO ☐
16. Do you have any disease, condition, or problem not listed? ..... YES ☐ NO ☐
17. WOMEN: Are you pregnant now? ..... YES ☐ NO ☐
    Are you practicing birth control? ..... YES ☐ NO ☐ Do you anticipate being pregnant? ..... YES ☐ NO ☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ _____ _____

Date *Signature of Patient, Parent or Guardian* *Dentist's Signature*

Complete reverse side, please

DENTAL HEALTH INFORMATION

How often do you brush your teeth? _____

What texture brush do you use? . . . . . SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐

How often do you floss? _____

Do your gums bleed while brushing? . . . . . YES ☐ NO ☐

Do your gums bleed while flossing? . . . . . YES ☐ NO ☐

Do you avoid brushing any part of your mouth because of pain? . . . . . YES ☐ NO ☐

If yes, what part? _____

Are your teeth sensitive? . . . . . YES ☐ NO ☐

To what? _____

Are you familiar with the term "preventive dentistry"? . . . . . YES ☐ NO ☐

Have your teeth ever been replaced by . . . . . fixed bridge ☐ removable partial ☐ denture ☐

Do you clench or grind your jaws while sleeping or during the day? . . . . . YES ☐ NO ☐

Do your jaws ever feel tired or painful? . . . . . YES ☐ NO ☐

Have you ever had your teeth straightened? YES ☐ NO ☐ When _____

Have you ever had a gum treatment? YES ☐ NO ☐ When _____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE

I have updated my medical history and my medications.

Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*
Date	*Signature of Patient, Parent or Guardian*	*Dentist's Signature*

BAYOU DENTAL P.A.
JAMES D. CALLAHAN, JR., D.D.S.
4461 BAYOU BOULEVARD PENSACOLA, FL 32503
(850) 476-5233

OFFICE POLICY

Welcome to our office. We would like to explain our office policies.

1. APPOINTMENTS

a. Our office has varied appointment hours available, and we will make every effort to meet your appointment needs.

b. We respect your time and will do our best to be on time for your appointment. We do endeavor to see emergencies as they arise and occasionally this may put us behind schedule, but rest assured that should you or a member of your family have an emergency, you will be seen on a priority basis also.

c. We ask that you respect our time by giving us a minimum of 24 hours notice of a change in your appointment with us. That will give us time to schedule another patient in the time period that was reserved for you. We reserve the right to charge a fee ($50.00) for broken appointments (less than 24 hours notice).

2. TREATMENT

a. Medical history, appropriate radiographs, and a complete oral exam will be done.

b. A plan of treatment will be made based on your requests and on our oral examination. Treatment, any alternative treatment, urgency, fees, and payment will be discussed. We encourage you to ASK QUESTIONS, for it is in your best interest to be as well informed as possible before you make any decision.

3. PAYMENT

a. Payment is due at the time of treatment. We accept Cash, Check, MasterCard, Visa, Discover and conventional insurance co-payments.

b. Dental Insurance claims will be processed for you by our office. Your estimated co-payment is due as treatment is provided. Please understand we will provide treatment for you the patient; WE DO NOT WORK FOR THE INSURANCE COMPANY. Please provide us the insured employee's name, address, social security number, place of employment group policy number, and mailing address and phone number of your insurance company.

c. Account balance over 61 days old will be accessed a service charge of 1 1/2% per month (18% per year) as allowed by Florida law.

d. Accounts with no payment made over the prior 60 days will be turned over to an outside collection agency for collection. A collection fee (up to 2/3 the balance due) may be added to cover the cost of collection. A delinquent account can damage one's credit rating for all credit for seven years.

e. Returned checks will be held by our office, must be picked up by you, and will be assessed a charge of $36.00 as allowed by law.

4. STATEMENTS

Statements will be sent on the 18th of each month to all our patients with a balance on their account. This will be a summary of all treatment, payments made by the patient, and payments made by the insurance company. Normally, insurance companies will make payments within 4 to 6 weeks following treatment. If yours is taking longer, we ask that you contact your insurance company and find out what the problem is. If you have any questions about your statement or insurance coverage, PLEASE CALL OUR BUSINESS OFFICE.

5. EMERGENCIES

a. During normal office hours: Please call, state the nature of the problem, and we will see you that day whenever possible.

b. After normal office hours: Please call the Doctor at home (the number is in the yellow pages) or call the office number.

6. OUR OFFICE STRIVES

to help each of our patients maintain his our her oral health in as comfortable, functional, and attractive a manner as possible. Should some problem occur with your mouth or OUR OFFICE, please notify our office or the Doctor. We thank you for any suggestions that will help us better serve you.

WELCOME to our fine family of patients. Referral of our office to your friends is the nicest compliment we can receive.

I understand and agree to the terms of this office policy.

Signature_____Date_____

BAYOU DENTAL, P.A.
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ACKNOWLEDGEMENT OF PRIVACY NOTICE

Your privacy is very important to us and we have always protected your privacy and your medical information. There is now a new federal law about your privacy called the Health Insurance Portability & Accountability Act of 1996 ("HIPAA").

HIPAA requires that we institute and follow several new privacy practices. We have outlined our privacy practices and procedures in our Notice of Privacy Practices. The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to that information.

This Notice is posted in our office and you are being provided a copy of it at your visit today. The Notice is subject to change, and if we change our Notice, you may get an updated copy upon request.

If you have any questions about the Notice or your right to receive it, please ask the front desk staff. If you have any questions about your privacy that are not answered in the Notice, please ask to speak to our Privacy Officer.

By signing below, you are acknowledging that you were provided a copy of our Notice of Privacy Practices.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices:

Signature of Patient or Legal Representative _____ Date _____ If Signed by Legal Representative, Relationship to Patient _____

James D. Callahan, DDS, P.A.
4461 Bayou Blvd.
Pensacola, Florida 32504
(850) 476-5233

DENTAL INSURANCE COVERAGE

It is important that we have the following information to properly handle your insurance claims.

PATIENT'S NAME _____ RELATIONSHIP TO EMPLOYEE _____

INSURED EMPLOYEE'S NAME _____ INSURED EMPLOYEE'S SS# _____

INSURED'S HOME ADDRESS _____

INSURED'S HOME PHONE _____ INSURED EMPLOYEE'S BIRTH DATE _____

INSURED'S EMPLOYER _____

INSURANCE CARRIER _____ INSURANCE PHONE # _____

INSURANCE ADDRESS _____

EMPLOYEE BENEFIT CONTACT PHONE # _____

OTHER INSURANCE INFORMATION _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

_____ _____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE ABOVE NAMED DENTIST.

_____ _____
SINGED (PATIENT OR PARENT IF MINOR) DATE

SECONDARY CARRIER

RELATIONSHIP TO EMPLOYEE _____ INSURED EMPLOYEE'S BIRTH DATE _____

INSURED EMPLOYEE'S NAME _____ INSURED EMPLOYEE'S SS# _____

INSURED EMPLOYEE'S HOME ADDRESS _____

INSURED EMPLOYEE'S HOME PHONE _____ INSURED EMPLOYEE'S WORK PHONE # _____

INSURED'S EMPLOYER _____

INSURANCE CARRIER _____ INSURANCE POLICY/GROUP # _____

INSURANCE ADDRESS _____ INSURANCE PHONE # _____

OTHER INSURANCE INFORMATION _____

Thank you for choosing Bayou Dental for all your dental needs. We are committed to providing you with quality and affordable dental care. Please read, sign, date and return our insurance and payment policy.

1. We participate with some dental insurance companies, and file all others as a courtesy. Knowing your insurance benefits is YOUR responsibility. Please contact your insurance company with any questions you may have regarding your specific plan benefits.

2. Co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect form patients can be considered fraud. Please help us by paying your out-of-pocket expenses at each visit. We collect the fees as quoted to us by your insurance as of the time of service. You will be responsible for any remaining balance due after insurance has settled your claim.

3. Please be aware that some of the services you receive may not be covered by your insurance company. Please be aware that most insurance companies either do not cover resin (white) fillings on molars or pay very little. Dr. Callahan will decide which material is better for your over all health and well being. We must obtain a copy of your current and valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be held responsible for the balance.

4. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

5. We gladly accept the following payment types- Visa, Master, and Discover cards, cash, Local checks, and the Care Credit card. We do not hold checks, or take partial payments unless otherwise negotiated.

Thank you for understanding our insurance and payment policies. Please let us know if you have any questions or concerns.

_____ _____

Patient or Patient's Representative Signature Date